STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HUMAN SERVICES

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PRINCIPLES OF REIMBURSEMENT

FOR

NURSING FACILITIES

EFFECTIVE OCTOBER 1, 2003

PRINCIPLES OF REIMBURSEMENT

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APPLICABLE FEDERAL AND STATE LAWS

Legal Basis for Program

The Rhode Island Medical Assistance Program was established on July 1, 1966, under the provision of Title XIX of the Social Security Act as amended by Public Law 89-97 which was enacted by the Congress on July 30, 1965. The enabling State Legislation is to be found in Title 40, Chapter 8 of the Rhode Island General Laws, 1956, as amended.

The Powers of the Director

Rhode Island General Laws 40-8-13 provides that the Director of the Department of Human Services, shall make and promulgate rules, regulations, and fee schedules, for the proper administration of the Medical Assistance Program, and to make the Department's State Plan for Medical Assistance conform to the provisions of the Federal Social Security Act.

Penalties for Misrepresentation or Fraudulent Acts

Penalties for misrepresentation or fraudulent acts involving this program are covered by both Section 1909 (a) of the Social Security Act, and Sections 11-41-3, 11-41-4, 40-8.2-3, 40-8.2-4 and 40-8.2-7 of the Rhode Island General Laws and any other applicable statutes. These criminal penalties are in addition to civil actions for damages, recoveries of overpayments, injunctions to prevent continuation of conduct in violation of Chapter 40-8.2, as well as suspension or debarment from participation in the program by state or federal authorities.

INTRODUCTION

It should be noted that commencing with the 1978 calendar year, the Rhode Island Medical Assistance Program began to make payment to participating facilities on a prospective basis.

Starting on October 1, 2003 the Department will begin to phase in provisions for rate reform to be completed on or before October 1, 2005. This rate reform will include the following elements:

Annual base years from every three years.

Four cost centers from seven cost centers.

Establishment of new cost center ceilings.

Re-array of costs of all facilities in the Direct Labor Cost Center (combined Labor Related and O.B.R.A. effective October 1, 2003) every three years.

Re-array of costs of all facilities in the Other Operating Cost Center (combined All Other and Management Cost Centers effective October 1, 2005) every three years.

Establishment of a Fair Rental System to replace the Other Property Related Cost Center effective July 1, 2004.

Establishment of a Pass Through Cost Center (combined Fixed Property, Energy and Insurance from the All Other Cost Center effective October 1, 2003) with no cost center ceiling.

This per diem reimbursement rate will represent full and total payment for services provided and, except for changes as a result of an audit of the facility's base year, appeal period or direct labor cost interim adjustment payment, will not be subject to a retrospective adjustment to reflect increases or decreases in actual costs.

III

RECORDS RETENTION AS PROVIDED FOR BY THE STATUTE OF LIMITATIONS (12-12-17)

Each provider of long term care services participating in the Title XIX Medical Assistance Program in accordance with the provisions of these Principles of Reimbursement will maintain within the State of Rhode Island all original records or hard copies of records and data necessary to support the accuracy of the entries on the annual BM-64 Cost Report. However, original invoices, canceled checks, contracts, minutes of board of directors meetings and any other material used in the preparation of the annual cost report must be retained in Rhode Island for at least ten (10) years following the month in which the cost report to which the materials apply is filed with the State Agency as required by the Statute of Limitation. Each provider will make available upon request such records and all other pertinent records to representatives of the State Agency, representatives of the Federal Department of Health and Human Services, and the State's Medicaid Fraud Unit within the State's Attorney General Office.

The State Agency will maintain all cost reports submitted by providers and all audit reports prepared by the Agency for at least ten (10) years after the month in which the cost report was filed by the provider or at least ten (10) years after the month in which the audit was conducted.

These Principles of Reimbursement are implemented in accordance with the appropriate provisions of the State's Administrative Procedures Act.

IV

The State will pay to participating providers of long term care facility services who

furnish services in accordance with the requirements of the Principles of Reimbursement the amount determined for services furnished by the provider under said Principles of Reimbursement.

If an overpayment to a participating provider of long term care services is identified, repayment will either be made by direct reimbursement or by offsetting future payments to the provider. Such repayment may include interest charges on the overpayment amount as provided for by Section 40-8.2-22 of the Rhode Island General Laws.

GENERAL

REPORTING

Reasonable Costs

The provision of Nursing Facility Care Services to Medicaid recipients is provided only to those individuals who are eligible for nursing facility services in accordance with Medicaid regulations relating to resources and income. Consequently, the cost of services for those individuals with limited income and resources must be reasonable. The Department of Human Services shall have the discretion to determine through its review of submitted costs, and in accordance with these principles, what constitutes reasonable and allowable cost.

Not all reasonable and allowable costs must be reimbursed. These Principles of Reimbursement, through application of rate ceilings, provide for payment of Nursing Facility Care services under the Medicaid Program on a prospective basis through rates that are reasonable and adequate to meet costs that must be incurred by efficiently and economically operated nursing facilities to provide services in conformance with state and federal laws, regulations, and quality and safety standards. Reasonable costs shall mean those cost of an individual facility for items, goods and services which, when compared, will not exceed the costs of like items, goods and services of comparable facilities in license and size. Reasonable costs include the ordinary, necessary and proper costs of providing acceptable health care subject to the regulations and limits contained herein.

Participants in the Medicaid program are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. Where it is determined that reported costs exceed those levels and

in the absence of proof that the situation was unavoidable, the excessive costs will be disallowed.

In the absence of specific definitions and/or elements of allowable and disallowable costs that may not be contained herein, the Rules and Regulations of Federal Medicare - Title XVIII will prevail.

The State reserves the right to make determinations of allowable costs in areas not specifically covered in the Principles or in the Rules and Regulations of Federal Medicare - Title XVIII.

Upper Limits

In no case may payment exceed the facility's customary charges to the general public or the federal upper payment limit for such services. The Upper Payment Limit is based on reasonable cost as is our payment.

Annual Cost Report BM-64

All facilities must file an annual cost report BM-64 on a calendar year. The report format is determined by the Center for Adult Health's Rate Setting Unit and must be filed on or before March 31 following the close of the year.

Newly constructed facilities will be allowed a temporary rate subject to the submission to the Chief Long Term Care Reimbursement of a BM-64 cost report covering a six-month period from the beginning of operations. The rate will be determined in the manner described for all other facilities under these principles and subject to the same ceilings.

The report must be completed in accordance with generally accepted accounting principles and prepared on the accrual basis of accounting wherein both revenues and

expenditures are recognized in the period when earned or incurred regardless of when actual cash payments are made and received.

Providers who do not submit the BM-64 on time without written authorized extension from the Rate Setting Unit will be assigned a non-recoverable reduction of 20 percent of the previously assigned rate. Such rate reduction will continue on a month-to-month basis until said BM-64 is submitted or facility is terminated from the program for failure to file BM-64 report within six months from the close of the reporting year.

A final BM-64 must be filed within 90 days after a change in ownership, closing of the facility or when the provider leaves the Medicaid program.

ADMISSION POLICY

Participating Nursing Facilities must admit Title XIX patients to all parts of the facility without discrimination in accordance with the provisions of Section 23-17.5-19 and 23-27.5-21 of the Rhode Island General Laws based solely upon specialized medical and related needs of the patient. In addition, as provided in Section 23-17.5-24 of the Rhode Island General Laws, patients shall have the right to remain in a facility after the depletion of private funds.

PARTICIPATION AND PAYMENTS

Facilities and at least 25% of all their nursing facility beds must be **dually certified** for participation in both the Federal Medicare - Title XVIII Program and the Rhode Island Medical Assistance - Medicaid Title XIX Program on and after October 1, 1990. Ideally all nursing facility beds should be dually certified.

The director of the Department of Human Services may waive the requirement for Medicare certification upon his or her determination, upon consultation with the director of

the state surveying agency, that: (1) there is an imminent peril to the public health, safety or welfare; and/or (2) it is in the best interest of the state and the residents of the facility.

METHOD FOR DETERMINING COST CENTER CEILINGS

NOTE: Effective for October 1, 2003, there is a continuation of the calculation of the ceilings for three cost centers. This calculation will continue until June 30, 2004 for the Other Property Related Cost Center and September 30, 2005 for the Management and All Other Cost Centers (excluding insurance cost ceiling portion included which is now included in the Pass Through Cost Center.)

On July 1, 2004, the Other Property Related Cost Center will be replaced by the Fair Rental Value System in the Property Cost Center, Reimbursement for that cost center will be such that a ceiling will not be calculated. Effective October 1, 2005, ceilings for the Management and All Other Cost Center will be replaced by a ceiling for the Other Operating Cost Center. The Other Operating Cost Center ceiling will be established by the Department between ninety percent (90%) and one hundred fifteen percent (115%) of the median for facilities for the most current array year.

BM-64 Cost Reports for calendar year 1991 for all certified and participating nursing facilities in continuous operation from January 1, 1991 through December 31, 1991, will be grouped into one level of care category and allowable cost per diems will be arrayed in descending order into the following three cost center per diem groupings: (a) Other Property Related Expenses, (b) All Other Expenses, and (c) Management Related Expenses. The appropriate percentiles as specified below will then be applied to this

arrayed data and except for Other Property Related, will be increased by the annual percentage adjustment recognized by the Rate Setting Unit of the Department of Human Services for rate years 1992 and 1993 and each subsequent July 1 beginning with the percentage adjustment recognized July 1, 1994,

BM-64 Cost Reports for the calendar year 2002 for all certified and participating nursing facilities (except for the Hospital Based Skilled Nursing Facilities) will be grouped and allowable cost per diems will be arrayed in descending order into the Direct Labor Cost Center. The appropriate percentile, 125% of the median for Direct Labor, will be applied to the arrayed data and will be increased by the percentage adjustment recognized by the Rate Setting Unit of the Department of Human Services effective July 1, 2003 and then each subsequent October 1st. Costs in the Direct Labor Cost Center will be arrayed every three years, the next array year being calendar year 2005 to establish a new maximum effective October 1, 2006.

The Pass Through Cost Center is such that a ceiling maximum is not calculated.

a. **Pass Through Items:**

This cost center grouping will include allowable costs reported in all account numbers as listed in Appendix 'E' – Chart of Accounts. Costs will be allowed without regard to a ceiling maximum. Each facility will report in Account No. 8470 the expenditure for the Health Care Provider Assessment. The costs in this item attributable to program revenue received will be fully recognized for reimbursement through an add-on to the per diem rate equal to the Health Care Provider Assessment as compounded.

b. **Other Property Related Expenses:**

This cost center grouping will include allowable costs reported in Accounts

No. 3452 - Interest, 3453 - Rent/Lease, 3453A - Lease of Equipment, 3454 – Amortization of Leasehold Improvements, 3455 - Building Depreciation, 3455A - Building Improvements Depreciation, 3457 -Equipment Depreciation and 3466 - Motor Vehicle Depreciation.

NOTE: This cost center grouping will be superceded by the application of a fair rental system to be developed by the Department for calculating allowable reimbursement for this cost center effective July 1, 2004.

Costs will be allowed up to a ceiling maximum of $18.97 for facilities licensed, under construction, or that have made a significant financial commitment by July 1, 1993, or that have submitted certificate of need applications by June 1, 1993 and have received approval by September 30, 1993. For these facilities, the $18.97 ceiling maximum will apply to any future additions of bed capacity that do not exceed the lesser of ten beds or 10 percent of existing bed capacity. Also for these facilities, upon change of owner/operator the ceiling maximum will become $15.00. Costs for additions to bed capacity that exceed the 10 bed/10 percent limit and costs for newly constructed facilities will be allowed up to a ceiling maximum of the 70th percentile of the cost of all facilities arrayed.

Nursing Facility Bed Replacement-Effective September 1, 1996:

Definition of Bed Replacement is defined as licensed beds newly constructed as an alternative to renovating existing licensed beds and meet the eligibility requirements below:

i. a licensed nursing facility, certified to participate in the Rhode Island Medical Assistance Program and in continuous operation and under the same ownership for reimbursement purposes since July 1, 1967, and

ii. costs for renovating existing physical plant to modernize and to conform to fire safety code laws governing nursing facility construction make the costs of renovations fiscally unsound. For those nursing facilities eligible to construct new nursing facility replacement beds the maximum allowable per diem cost in the Other Property Related Expenses cost center will be set at the rate of $18.97 subject to the following conditions:

a) replacement beds are licensed in a number no greater than the actual beds licensed in the existing facility, unless additional beds are approved by the Department of Health prior to January 1, 2001, and constructed on one site, not multiple sites, and

b) if fewer replacement beds are constructed than are licensed in the existing facility the license for the difference in beds will be unconditionally surrendered to the Department of Health, and

c) the certificate of need for the replacement beds must be granted no later than January 1, 2001, and

d) at the time replacement beds become licensed, the existing facility shall unconditionally cease operation as a nursing facility, and

e) notwithstanding any provision in section "Recovery of Depreciation" of the Principles of Reimbursement to the contrary, recapture of depreciation will be paid to the State of Rhode Island upon the sale of the existing facility whenever occurring and regardless of the proposed or actual use of the existing facility by the purchaser.

c. **Direct Labor:**

This cost center grouping will include allowable costs in all account numbers

as listed in Appendix 'E' – Chart of Accounts. Costs will be allowed up to a ceiling maximum of 125% of the median of the costs of all facilities arrayed.

Nursing facilities whose allowable 2002 direct labor costs are below the median in the direct labor cost center may make application to the Department's Rate Setting and Auditing Unit for a direct labor cost interim payment adjustment equal to twenty-five (25%) of the amount such allowable 2002 direct labor costs are below the median. This interim payment adjustment will be granted on or after October 1, 2003. The interim payment adjustment must be expended on expenses allowable within the direct labor cost center and any portion of the interim payment not expended on allowable direct labor cost center expenses will be subject to retroactive adjustment and recoupment by the Department. The Department will determine the final direct labor payment adjustment after review of the facility's actual direct labor expenditures. The final direct labor payment adjustment will be included in the facility's October 1, 2004 rate until the facility's next base year.

d. **All Other Expenses:**

NOTE: This cost center grouping will be combined with the Management cost center group effective October 1, 2005 to form the Other Operating cost center. A ceiling maximum at that time will be established by the Department between ninety percent (90%) and one hundred fifteen percent (115%) of the median for all facilities for the most recent array year.

This cost center grouping will include all other allowable costs not specifically covered by grouping a, b, c, e. Costs will be allowed up to a ceiling maximum of the 80th

percentile of the cost of all facilities arrayed.

e. **Management Related Expenses:**

NOTE: This cost center grouping will be combined with the All Other Expenses cost center group effective October 1, 2005 to form the Other Operating cost center. A ceiling maximum at that time will be established by the Department between ninety percent (90% and one hundred fifteen percent (115%) of the median for all facilities for the most recent array year.

This cost center grouping will include all allowable costs reported in Accounts No. 7411-Administrator, 7412 - Officers/Owners, 7421 - Other Administrative Salaries, 7431 - Health Care Plan (Employer's share-portion attributable to personnel included within this cost center), 7432 - Other Employee Fringe Benefits (portion attributable to personnel included within this cost center), 7433 - Home Office/Central Services (portion attributable to labor and payroll-related expenses), 7435 - Computer Payroll/Data Processing Charges, 7436 - Accounting/Auditing Fees, 7437 - Legal Services, 7440 - Payroll Taxes (portion attributable to personnel included within this cost center), 7442 - Insurance (Workers Compensation, group life, pension and retirement-portion attributable to personnel included within this cost center), 7444A -Utilization Review Medicaid Title XIX, 7449A - Miscellaneous Labor & Payroll Related, 7523 - Dietary Consultant, 7712 - Pharmacists Salaries/Fee and effective September 1, 1996 cost will be allowed up to a ceiling maximum of the 80th percentile of the cost of all facilities.

METHOD OF DETERMINING INDIVIDUAL PROSPECTIVE RATES

Note: Due to the changes to the Principles of Reimbursement effective October 1, 2003, certain rate calculations remain in effect until October 1, 2005. This applies to

the Other Property Related Cost Center, (until July 1, 2004), All Other Cost Center and Management Cost Center. These calculations are listed in numbers 1 through 5.

1. Each facility in operation during calendar year 1991 shall have its base year established in accordance with 'Appendix A' Audit Scheduling for all cost centers described in a., b., c., d., e., f. and g. above. Any facility commencing operation subsequent to calendar year 1991, shall have its first six months of operation as its base period.

2. Effective July 1, 1993, each facility will be assigned interim prospective rates utilizing the facility's base year BM-64 cost report adjusted by the percentage change in the National Nursing Home Input Price Index recognized by the Rate Setting Unit of the Department of Human Services for rate years subsequent to the audited year up to and including rate year 1993 and in lieu of the application of the percentage increase for the rate year July 1, 1996 through June 30 1997 there shall be an additional price index adjustment of nine-tenths of one percent (.9%) effective July 1, 1999 and subject to cost center maximums described in b., d., e., above. The interim prospective per diem rate will be adjusted, if necessary, through results of an audit of base year costs.

3. An additional interim per diem rate will be calculated and added to each nursing facility rate to recognize reimbursement for expenditure in account #8470 Health Care Provider Assessment for Rhode Island Medical Assistance Program revenue.

4. Starting with the reporting year 1991 and with every reporting year thereafter, one-third of the participating facilities will have a new base year. The prospective rate of each facility with a new base year will be recalculated after the completion of an audit and

will be effective July 1 of the year subsequent to the year in which the audit was scheduled. The recalculated rate will reflect the actual allowable costs as determined by the audit updated by the National Nursing Home Input Price Index percentage increase(s) for the year(s) subsequent to the audited year, and in lieu of the application of the percentage increase for the rate year July 1, 1996 through June 30 1997 there shall be an additional price index adjustment of nine-tenths of one percent (.9%) effective July 1, 1999, to produce the prospective rate; provided, however, that the new prospective rate does not exceed the maximum rates established for each cost center ceiling. 5. Commencing with the State fiscal year beginning July 1, 1994 and each State fiscal year thereafter, excluding however the rate year July 1, 1996 through June 30, 1997, the annual percentage increase will be applied to all cost centers excluding the $18.97 and the $15.00 ceiling maximums identified in paragraph b. Above entitled "Other Property Related Expenses" to determine new cost center ceilings. Commencing July 1, 1994, excluding however the rate year July 1, 1996 through June 30, 1997, individual facility cost center rates, excluding the cost center rate for Other Property Related Expenses Cost Center, will be adjusted annually by the amount of percentage change in the National Nursing Home Input Price Index for the twelve (12) month period ending the previous March. The amount of percentage change to be utilized will be the index as projected by the Centers for Medicare and Medicaid Services on the first date it is available in the month of May each year. Although the index may be obtained initially by telephone, it will be confirmed in writing.

6. Effective October 1, 2003 for the Direct Labor and Pass Through Items Cost Center, each facility will be assigned interim prospective rates utilizing the facility's base

year 2002 BM-64 Cost Report adjusted by the percentage change in the National Nursing Home Input Price Index recognized by the Rate Setting Unit of the Department of Human Services for rate years subsequent to the base year. Each facility will have a new interim rate assigned each October 1st in these two (2) cost centers, based on the immediate prior calendar year cost report, increased by the recognized percentage change applied as of July 1. The interim prospective per diem rate will be adjusted, if necessary, through results of a field audit of base year costs for the Direct Labor and Pass Through Items Cost Center.

Temporary Rates for Newly Acquired or Constructed Facilities

Newly constructed facilities and facilities that change ownership will be allowed a temporary reimbursement rate after supplying the Chief Long Term Care Reimbursement sufficient cost data or other information necessary to fairly calculate interim per diem rates, subject to the maximum cost center ceilings as established in each of the seven cost center categories. Upon completion of a six-month period from time of licensure, the facility will complete and file with the Chief Long Term Reimbursement for Nursing Facilities, a cost report form BM-64 covering the first six months of operations. Based upon the analysis of the report and Principles of Reimbursement in effect at the time of licensure, a new rate may be calculated, subject to the maximum cost center ceilings as established, and made retroactive to the date of licensure

Proforma cost data and BM-64 cost reports covering the first six month of operations submitted by newly acquired or constructed facilities will not be considered in the array of cost information for the determination of the maximum allowable base in each of the cost

center category.

APPEALS PROCESS

NOTE: This section on appeals process will be amended effective October 1, 2005 to include a provision that it shall apply to demonstrated errors made during the rate determination process.

Any provider who is not in agreement, after being provided an exit audit conference or rate appeal conference, with the final rate of reimbursement assigned as the result of the audit for their base year, or with the application of the Principles of Reimbursement for the applicable calendar years, may within 15 days from the date of notification of audit results or rate assignment file a written request for a review conference to be conducted by the Associate Director, Division of Health Care, Quality, Financing and Purchasing, or other designee assigned by the Director of the Department of Human Services. The written request must identify the remaining contested audit adjustment(s) or rate assignment issue(s). The Associate Director or designee shall schedule a review conference within 15 days of receipt of said request. As a result of the review conference, the Associate Director or designee may modify the audit adjustments and the rate of reimbursement. The Associate Director or designee shall provide the provider with a written decision within 30 days from the date of the review conference.

Appeals beyond the Associate Director or the designee appointed by the Director of the Department of Human Service's will be in accordance with the Administrative Procedures Act. The provider must file a written request for an Administrative Procedures Act hearing no later than 15 days of the decision noted in the paragraph above.

APPEAL REQUESTS FOR RATE INCREMENTS

NOTE: This section on appeal requests with the exception of item f. is hereby repealed in its entirety effective October 1, 2005.

In those cases in which the assigned prospective rate of a facility falls below the new aggregate ceiling maximum, the Department of Human Services can consider the granting of a prospective rate that reflects demonstrated cost increases in excess of the rate that has been established by the application of the percentage increase. In order to qualify for such a rate increment, demonstrated increased costs must be a result from:

a. Demonstrated errors made during the rate determination process,

b. Significant increases in operating costs resulting from the implementation of new or additional programs, services or staff specifically mandated by the Rhode Island Department of Health,

c. Significant increases in operating costs resulting from capital renovations, expansion, or replacement required for compliance with Fire Safety Codes and/or Certification requirements of the Rhode Island Department of Health, or,

d. Significant increases in Workers Compensation and/or Health Insurance premiums which cannot be accommodated within the facility's assigned aggregate per diem rate will be allowed a rate increment, if cost justified, so long as the new assigned per diem rates in the Labor Related Expenses cost center and in the Management Related Expenses cost center do not exceed two-percent (2%) of said cost center ceilings, or,

e. Extraordinary circumstances, including, but not limited to, acts of God, and inordinate increases in energy costs (e.g., federal BTU tax, regional or national energy crisis). Inordinate increases in energy costs will be immediately reflected in increased rates

above the energy cost center ceiling maximum. Provided, however, that such increases will be rescinded immediately upon cessation of the extraordinary circumstance.

Initial requests for prospective rate adjustments in excess of those that would be established through application of established percentage increase, will first be reviewed by the Rate Setting Unit within the Center for Adult Health within the Department of Human Services. This Unit will be empowered to grant such variances, provided that the facility involved meets the above criteria and provides all the necessary data.

Requests for rate increments will be limited to one request per annum per facility for the factors specified in items (b) (c) and (d) above. However, additional requests involving a recurring per diem increase in excess of one percent of the facility's previously assigned aggregate per diem rate will also be reviewed. Before a facility files for a rate increment, increases in operating costs addressed in (b) (c) and (d) above must have been incurred for at least a three-month period in order to establish proof of such increase.

All costs, including salaries, must be absorbed within these group ceilings. The total ceiling maximum will be the sum total of the seven cost center ceilings.

f. In addition to the above appeal requests, a facility may qualify for a rate increment adjustment, as determined by the department, in accordance with this subsection:

(a) The facility is located in a federally designated Enterprise Community; and

(b) The facility is incurring allowable costs in one or more cost centers in excess of the allowable maximum for such cost center(s); and

(c) The facility files a written request for a rate increment with the department which must include the following documentation:

i. A cost containment and revenue enhancement plan; and

ii. A cost report for the most recently completed six (6) months of operations; and

iii. Such other documents as may be requested by the department.

The department shall review the written request and may grant a rate increment adjustment to become effective not earlier than the month the request was filed which:

1. may result in a per diem rate which shall not exceed the aggregate of all cost center maximums, plus the per diem rate to recognize reimbursement for the health care provider assessment in account #8470; and

2. will be limited for a period not to exceed twenty-four (24) consecutive months; and the facility may reapply for a rate increment adjustment under this subsection for a period of twenty-four (24) consecutive months following the month of expiration or termination of an approved rate increment adjustment; and

3. subject to the aggregate limit in (1) above, may recognize reasonable and necessary costs incurred by the facility to achieve the cost containment/revenue enhancement plan approved by the department; and

4. will be established for an initial six (6) month period, and may be extended and adjusted by the department for an additional six (6) month periods (but not to exceed the overall maximum twenty-four (24) month limit); and

5. will be subject to continuing review and monitoring by the department and such terms and conditions to be specified by the department in a rate increment approval letter (for initial and extended periods) to the facility.

Rate adjustments granted as a result of a request filed within 120 days after the

costs were first incurred will be made effective retroactively to the date such costs were incurred. However, any adjustments granted as a result of requests filed beyond 120 days after the costs were first incurred will be effective on the first day of the month following the filing of the request.

PAYMENTS

The State of Rhode Island reimburses a provider monthly for Medicaid patient days times the assigned prospective per diem rate. This also applies to State only days.

The State of Rhode Island reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

In determining the number of days for which payment may be made the date of admission is counted, however the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under State General Law Section 40-8.2-3 and Federal regulations, subsidy for patient care by either the patient, relatives or friends to the facility in any manner is prohibited.

RECORDKEEPING

Adequacy of Cost Information

Providers of Long Term Care under the State Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable to substantiating the reasonableness of specific reported costs. Records include all ledgers, books and

source documents (invoices, purchase orders, time cards or other employee attendance data, etc.). All records must be physically maintained within the State of Rhode Island.

Census Data

Statistical records supporting both Medicaid and total patient days must be maintained in a clear and consistent manner for all reporting periods. The detailed record of all patient days must be in agreement with monthly attendance reports and shall be the denominator used in the computation for determining per diem rates providing that said patient days are equal to or greater than 98% of the statewide average occupancy rate of the prior calendar year. In calculating patient days the date of admission is counted as one day, however, the date of death or discharge is not counted as a day.

AUDIT OF PROVIDER COSTS

In accordance with 45 CFR-250.30 p.(3) (ii) (B) all cost reports will be desk audited within six months of submission.

The State of Rhode Island, Rate Setting Unit, shall conduct audits of the financial and statistical records of each participating provider in operation.

Audits will be conducted under generally accepted auditing standards and will insure that providers are reporting under generally accepted accounting principles.

Other matters of audit significance which will be undertaken are the examination of construction costs and final cost reports. All costs of new construction will be audited by the State as herein described. Final cost reports submitted by a provider due to change in ownership, closing of a facility or discontinuance in the Medicaid Program shall be subject to audit within a reasonable time after such change has taken place.

Services and affiliated organizations where common ownership exists shall also be subject to audit. The extent of the audits will depend primarily on the relative dollar impact of these service groups.

Audits will include any tests of the provider's records deemed necessary to ascertain that costs are proper and in accordance with Medicaid principles of reimbursement and that personal needs accountability is in compliance with existing regulations. The knowing and willful inclusion on non-business related expenses, non-patient related expenses, or costs incurred in violation of the prudent buyer concept may be subject to criminal and/or civil sanctions. Failure of auditors of the Department to identify the above items or their adjustment of same shall not constitute a waiver of any civil or criminal penalty.

OPERATING COSTS

DEPRECIATION

General

Reasonable costs incurred in providing services to Medicaid patients include depreciation on the building, equipment and transportation vehicles used to carry out necessary services. Following are the prescribed procedures for determining the allowable depreciation.

Capitalization Policy

The following policy on expenditures for depreciable assets is applicable regardless of standards established by the provider. Individual assets with a cost of $300.00 or more and a useful life of at least two years must be capitalized. Assets acquired in quantity at a total cost of $500.00 or more and multiple purchases of similar individual assets during a

reporting period must be capitalized if the total cost is $500.00 or more and the assets have a useful life of at least two years.

Painting, redecorating or renovating, whether interior or exterior, of the entire facility or of a substantial portion of a wing or floor must be capitalized.

Method of Depreciation

For reimbursement purposes, only straight-line depreciation is permitted. This method provides for ratably charging to operations the actual asset cost less salvage value based on useful life.

The useful life of each asset will be subject to the American Hospital Association useful lives schedule (see Appendix 'B').

Component depreciation will be allowed subject to and with written approval of the Rate Setting Unit. In conjunction with component depreciation, allocable and other fees, services and items which cannot be specifically identified to a particular component will be depreciated on the basis of a forty (40) year life. Examples of allocable are, but not limited to the following: Architect fees, interest, real estate taxes and insurance during the time of construction, builders' overhead and profit, title fees, legal and recording fees, bond premiums, site studies and surveys, financing fees, etc.

Cost Basis for Depreciation Purposes

Asset acquisitions during a facility's base year will be annualized for prospective calendar years if the depreciation claimed for the base year is less than a twelve-month period.

Newly Constructed Facilities and Expansion of Existing Facilities

Construction costs approved by the Department of Health will constitute the maximum basis on which depreciation may be calculated subject to the maximum ceiling imposed under other property related expenses cost center. Costs must be bona fide, properly supported, and will be subject to audit by the State.

The useful lives of assets as approved by the Rate Setting Unit may not be changed by the provider without prior authorization in writing from the Rate Setting Unit. If such a change is approved, it will be effective July 1 of the year following the year in which the request was filed.

Demolition Costs

Demolition costs incurred for new construction and/or expansion are to be considered as follows:

a. Demolition cost and the recognized undepreciated base of a facility that was participating in the Medicaid Program just prior to demolition will be added to and become part of the new depreciable base of the new facility.

b. Demolition cost of a structure not previously enrolled in the Medicaid Program will be considered as site development costs and be added to cost of land.

Purchased Facilities

The cost basis of a facility and its depreciable assets acquired as an on-going operation in a bona fide sale, will be limited to the lowest on the following:

1. fair market value of buildings, improvements and tangible assets purchased,
2. price paid by the purchaser,
3. current reproduction costs depreciated on a straight-line basis over the useful life of the assets to the time of sale,

4. the valuation of capital assets (excluding furniture, fixtures and equipment, which shall be the lesser of sale price or net book value) will be not increased (as measured from the date of acquisition by the seller to the date of the change in ownership) solely as a result of a change of ownership, by more than the lesser of: --

(i) one-half of the percentage increase (as measured over the same period of time) in the Dodge Construction Systems Costs for Nursing Homes, or

(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States City Average).

The cost basis of buildings, improvements and other depreciable assets in a sale that is not a bona fide sale, cannot exceed the seller's cost basis, less accumulated depreciation. The burden of proof of whether such sale is or is not bona fide will rest upon the purchaser.

Whenever the allocation of cost to acquired assets appears unreasonable, independent appraisals of property values will be obtained by the Department of Health for the purpose of assigning cost values.

Costs associated with the sale and acquisition of capital stock will not be recognized for reimbursement purposes. Re-evaluation of assets will not be recognized nor will the financing cost attributable to the stock purchase. The amount of depreciation expense and interest expense to be recognized for reimbursement will be the amount recognized by the Rhode Island Medical Assistance Program as remaining to be amortized prior to the stock acquisition.

Transfer of Ownership, Real Estate Holding Entities and/or Operating Entities Among Related Parties

Where there is a transfer or sale of corporate stock or transfer or sale of ownership from corporate officer(s) to other corporate officer(s), from partner(s) to partner(s), or between parties in which these is a common ownership the basis and approved method of depreciation, and the reimbursable interest cost prior to said transfer will be allowed the new owners.

Transportation Vehicles

The allowance for depreciation on vehicles used to transport patient and for other official business purposes is based on the following schedule:

NUMBER OF BEDS	VEHICLES ALLOWED
35 or less	1 vehicle
36 - 75	1 1/2 vehicle
over 75 beds	maximum of 2 vehicles

Recreation vans (RV) - no allowance will be recognized.

1-4 Passenger sports auto-no allowance will be recognized.

4-6 Passenger auto - depreciable base limit - $12,000.00

5-9 Passenger station wagon - depreciable base limit - $15,000.00

Wheelchair Lift Vans - Depreciable base limit $41,618 - indexed by one-half of the National Nursing Home Input Index each January 1 beginning January 1, 2004 and depreciated over a six year life utilizing straight line method of depreciation.

Passenger vans with lifts with a cost in excess of $35,000 - depreciable base limit

will be determined based upon the facts in each instance. Prior written approval from the Rate Setting Unit is mandatory. The number of Medicaid patients and the nature of the service provided by a facility will be considered in this determination.

Travel log(s) must be maintained for each vehicle in which a reimbursement allowance is recognized showing vehicle identification number, date, driver, beginning and ending odometer readings, passenger names, except for group activities when the number of patients must be recorded, destination and purpose of travel. If the travel logs indicate less than 100% nursing facility business use, only the percentage attributable to nursing facility business use will be recognized.

Recognized depreciation on motor vehicles shall be in accordance with depreciation attributable to first the oldest auto acquired or leased on the records of the facility and second, if the facility is entitled to more than one vehicle, to the next oldest vehicle acquired or leased on the records of the facility.

Expenditures for gas, oil, repairs of transportation vehicles will be allowable to the extent of the number of vehicles permissible under the principles even if the vehicles are fully depreciated.

However, in all cases, the Department of Human Services reserves the right to make the determination of entitlement based upon the facts in each instance. The number of Medicaid patients and the nature of the service provided by a facility will be considered in this determination.

Donated Assets

Where certain assets have been donated, their basis for depreciation purposes shall

be the fair market value on the date of donation.

Sales Commissions and Brokerage Fees

Sales commission and brokerage fees are includable in the new owner's depreciable base subject to prior written approval from the Department of Health, Division of Medical Care Standards and the Department of Human Services.

RECOVERY OF DEPRECIATION

Sale of Real Property

An agreement to sell a facility in whole or in part must provide that written approval be obtained from the Department of Health as a condition to licensure and cost reimbursement. Also, the seller must submit a copy of a Purchase & Sales Agreement, to both the Department of Health and the Department of Human Services before the closing in order to facilitate final settlement between the State and the facility. The State must respond with 60 days.

Real Property

The State will recover allowed depreciation from any excess proceeds realized on the sale of a nursing facility. The excess proceeds represents the excess of the selling price over book value (cost minus the depreciation used for reimbursement purposes).

The depreciation to be recovered will be computed as follows for all sales on or after September 1, 1996:

a. Period commencing January 1, 1972: The amount of depreciation subject to recovery by the State will be reduced by 2 1/2 percent for each year the asset has participated in the program since January 1, 1972.

Recovery of depreciation will never exceed actual amounts paid for depreciation

costs as a part of the per diem reimbursement rate. In those instances where the actual per diem costs exceed the maximum per diem reimbursement rate, the appropriate percentage factor will be utilized in order to ensure that only depreciation actually paid for will be subject to recapture.

Notwithstanding the above recovery of depreciation provisions, the State will not recover depreciation with respect to the following facility sales:

1. Any sale of a nursing facility more than two years after the date such facility voluntarily or involuntarily ceases to participate in the Rhode Island Medical Assistance Program; or

2. A sale of a nursing facility within two years of the date that such facility voluntarily or involuntarily ceases to participate in the Rhode Island Medical Assistance Program, provided that within said two year period, the facility begins operation as a licensed sheltered care facility pursuant to Chapter 23-17.4 of the R.I. General Laws.

Personal Property

The same rules listed above also apply to the recovery of depreciation on any gain realized on the sale of personal property (equipment, furniture, fixtures, motor vehicles, etc.).

Method of Payment

Amounts due the State for recovery of depreciation as a result of the sale of any entire facility as an ongoing operation must be paid at the final closing. Amounts due as a result of the sale of personal property of an ongoing facility will be paid by reducing the monthly vendor payroll. For other amounts due the State, the seller may for sufficient cause request additional payment time, the granting of which may require the execution of

an escrow agreement with the State.

Gain or Loss on the Trade-In of Depreciable Personal Property

No gain or loss is recognized on the Trade-In of a depreciable personal asset toward the purchase of a similar asset. However, the basis of the newly acquired property must be adjusted to reflect a basis equal to the sum of the:

a. Cost less depreciation allowed for reimbursement of the asset traded,

b. Additional funds provided to purchase the new asset.

INTEREST

Long-Term Financing

Certain limitations on allowable interest costs are applicable to facilities commencing operations, expanding existing operations, or transferring ownership on or after January 1, 1977 unless an irrevocable financing agreement or buy/sell agreement has been executed prior to 1-1-77. These limitation are enumerated below:

1. **Minimum Investment** - A minimum equity investment equal to 10 percent of the total cost is required to obtain recognition of interest expense on mortgage indebtedness on the construction of capital assets or for the acquisition of ownership in a nursing facility. This requirement can be fulfilled by but not limited to, the following:

a. Capital contribution

b. Non-interest bearing loan to facility. If the loan is interest bearing, the interest will not be recognized.

c. Appraised value of depreciable assets contribution in accordance with American Hospital Association regulations.

d. Appraised value of land contribution exceeding 50 percent of equity

requirement.

Interest expense on long term financing will be limited to the application of the interest calculated on the lower of actual principal financed or 90 percent of the recognized cost basis for Medicaid depreciation purposes.

2. **Rate of Interest** - The rate of interest will be subject to review by the State. If the rate is found to be in excess of those rates charged by banks and other lending institutions, the State may withhold licensing approval or adjust the rate downward for reimbursement purposes.

Financing Charges

Sometimes banking and other lending institutions impose charges which are in addition to and separate from stated interest amounts. Those amounts will be considered as allowable subject to the following condition: - The finance charges must be a mandatory requirement imposed by the lender as a condition of granting the loan.

Finance charges must be amortized ratably over the term of the loan.

Current Financing

Interest costs on bona fide loans for working capital and other current needs relating to patient care are generally reimbursable subject to prior written approval from the Department of Human Services. Interest on working capital loans is limited to 60 days operating needs for a loan term not exceeding 18 months unless prior written approval is received from Human Services and the need is substantiated by a cash flow statement. Emergency short-term loans repayable within 30 days will require no prior approval. Interest expense for working capital loans necessitated by excessive demands on cash flow

within the past three (3) year period for non-reimbursable expenses will not be recognized. Such demands of cash could be caused by, but not limited to, the following:

1. Payment of rent/lease to a related realty, individuals and/or entity of the cash requirements of the real estate expenses such as mortgage principal and interest payments, taxes, insurance, etc.

2. Payments to officers, owners and/or family members in excess of the recognized reimbursement compensation pursuant to these Principles for these individuals.

3. Payments made on behalf of officers, owners and/or family members for un-reimbursable expenses, such as but not limited to, fringe benefits, conventions and meeting, travel, etc.

4. Payments made to a management company or central home office in excess of the facility's pro-rated share of recognized expenses.

Finder's Fees

A fee paid to a third party for bringing together the lender and borrower and/or buyer and seller is not reimbursable.

Imputed Interest

Under certain circumstances, the State shall impute interest on loans or advances made by or to a facility in any amount in excess of $10,000.00 per annum. All loans and advances must be evidenced by a written executed instrument together with a demonstrated need for such borrowing or advance.

Loans or advances made directly or indirectly to an owner, officer, affiliated organization, or other party at little or not charge by a facility with outstanding debt shall be subject to imputed interest. The rate used by the State in calculating imputed interest shall

be the prime interest rate as utilized by Fleet Bank on the day of the loan or advance. The resultant interest income will be used to offset interest expense claimed by the facility.

A facility borrowing funds from an owner(s), partner(s), officer(s), or affiliated organization(s) for bona fide reasons approved by the Rate Setting Unit will be entitled to claim imputed interest as reimbursable cost based upon the prime interest rate as utilized by Fleet Bank on the day of the borrowing. Imputed interest for such borrowings will only by recognized if written approval is sought and obtained from the Rate Setting Unit prior to the execution of the written instrument documenting the loan or advance.

Imputed interest does not apply to the minimum equity investment requirement.

REAL ESTATE AND PERSONAL PROPERTY TAXES

For Medicaid purposes, the allowable real estate and personal property taxes will be the four quarterly amounts due and payable during the reporting year or the tax based upon the assessed valuations of the prior December 31. For example, the amount allowable for calendar year 2001 will be the four quarterly installments due and payable during calendar year 2001 or the total tax based on the December 31, 2000 valuations. The basis for reporting will be determined by the provider but must remain consistent from year to year.

PERSONNEL COSTS

Compensation of Owners

Compensation to an owner or related individual must be reasonable and associated with patient care in order to be reimbursable.

Criteria for Determining Reasonable Compensation to Owners and/or Related Individuals

In judging for reasonableness, the Chief Long Term Care Reimbursement may use but is not limited to:

1. Comparison with payments to individuals, other than owners, in comparable facilities or industries.

2. Equating responsibilities and functions performed with a satisfactory salary range.

The allowance for fringe benefits must be consistent with the compensation above.

Compensation of Administrators

An administrator must be a duly licensed person in the State of Rhode Island and be responsible for the overall management and supervision of a facility. Administrators must work on a full time basis and be substantiated by appropriate time records. Assistant Administrators working full time or part time must also be substantiated by time records. Compensation of an administrator is an allowable cost to the extent it does not exceed established maximums governed by bed capacity as shown on the attached schedule, Appendix 'C'. Effective September 1, 1996 Nursing Facilities with a licensed bed compliment of 75 beds or less will be reimbursed based on current allowable costs for the administrator's salary. Said reimbursement will be subject to the ceiling maximums and the provisions as outlined below.

A Nursing Facility with a licensed bed compliment of 75 beds or less that is not fully recognized for reimbursement for the administrator's salary because of the Management Related cost center maximum and whose actual cost is equal to or less than the limitations on appendix 'C', and is reimbursed for an amount less than the Direct Labor Expenses cost center maximum can receive an amount up to 50 percent of the difference between the

Labor Related Expenses cost center maximum and the rate assigned in that cost center to accommodate up to the full administrators salary.

Appendix 'C' will be adjusted annually commencing July 1, 2004 by the amount of percentage change reflected by the Wage and Salary Component of the National Nursing Home Input Price Index as projected by the Health Care Financing Administration for the twelve-month period ending the previous March.

Facilities Operated by Members of a Religious Order

The recognized salary allowance for members of a religious order providing patient care services will be limited to the lower of actual stipend paid on their behalf or the salary equivalent that would be recognized by these Principles of Reimbursement for similar services.

RENTAL AND LEASE PAYMENTS

General

Rental and/or lease agreements originating on and after January 1, 1985 may be recognized for reimbursement providing the amount does not exceed ownership costs, such as mortgage interest and depreciation.

Agreements Between Affiliated Parties

Where rent and/or lease agreements are between related individuals as defined by H.I.M.-15, or by corporate officers, or partners, or parties in which there is a common ownership or from related organizations, or any combination thereof the recognized amount for Medicaid reporting shall constitute the actual cost of said rental property consisting of such elements as depreciation, mortgage interest and real estate taxes.

Distinguishing Between a Rental and a Purchase

Reporting for leases in the annual cost report may require special treatment depending upon the circumstances. Where it is apparent that the transaction involved is in substance a purchase, the leased property should be included among the assets of the lessee with suitable accounting for the corresponding liabilities and for the related charges. The following conditions will generally establish that a lease is a virtual purchase.

a. The rental charge exceeds charges of comparable equipment in the area.

b. The term of the lease is less than the useful life of the equipment.

c. The lessee has the option to renew the lease at a significantly reduced rental.

d. The lessee has the right to purchase the equipment at a price which appears to be significantly less than the fair market value.

PROFESSIONAL SERVICES

The fees must meet the test of reasonable costs, and must be fully documented by billing which clearly describes the nature of the services rendered.

An example of admissible cost is the fee for legal services in connection with a directive to comply with fire codes regulations. A legal or accounting charge resulting from a buy/sell agreement between related parties is inadmissable. Professional fees associated with future construction must be deferred and included with the project construction costs.

FRINGE BENEFITS

Fringe benefits such as prepaid health insurance, group life insurance, employees child day care, dental plans, and retirement plans, are allowable costs, providing they are offered to all full-time employees. Similar benefits or partial benefits offered to all

permanent part-time employees working at least twenty hours per week will also be recognized. Fringe benefits which advantage officers, owners, or other related individuals in a disproportionate manner will be adjusted to reflect equity of application. Fringe benefits by employee classification must be addressed in the facility's personnel and policy manual in order to be recognized. Benefits other than those stated above must have the prior written approval of the Rate Setting Unit and must be reasonable and necessary for the efficient, effective and economical operation of similar facilities participating in the Rhode Island Medicaid Program.

New fringe benefits provided to full time and permanent part time employees working at least twenty hours per week during a facility's base year will be annualized for prospective calendar years if the cost of the new benefit during the base year was less than a twelve month period. Upgrading and/or substitution of benefits does not qualify for this provision. New fringe benefits must continue through prospective years otherwise a rate reduction will be assigned retroactive to the date benefits were discontinued.

Vacation time and sick leave time are not recognized for reimbursement under the accrual method of accounting and will not be recognized for annualization of new fringe benefits. Vacation time and sick leave time will be recognized as an expense when actually paid to the employee by the facility.

Profit Sharing Plans: Profit sharing plans must continue in prospective periods at a rate equal to the base period. Failure to fund at a level equal to the amount being reimbursed will result in a recovery of reimbursed costs. This will also result in a reduction to the assigned per diem rate of reimbursement.

OTHER OPERATING COSTS

All operating costs, including nursing, medicine chest, and over-the-counter drug supplies which have been determined as reasonable and acceptable will be allowed after reduction for items not related to patient care.

ACCOUNTING AND AUDITING FEES

Accounting and Auditing services are generally a necessary and proper function in the fiscal operation of long term care facilities. Recognized fees associated with these services must be clearly identified by the employed firm as to responsibility, function of activity, hourly billing rate and time element for each function. The Rate Setting Unit shall determine an appropriate amount for such services to be recognized for reimbursement purposes taking into consideration such factors as; facility employed accountant(s), controller(s), comptroller(s), bookkeeper(s), condition of books and records maintained by the facility, and the necessary direct involvement of the Accounting/Auditing firm.

STAFF UTILIZATION

Utilization of labor during a base period/base year for which a rate of reimbursement has been established, must be maintained during prospective reimbursement periods. Decreases in labor hours and expenditures will result in an amount due the Rhode Island Medicaid Program for the period in which such decrease in hours and expenditures occurred and will also result in a decrease in the rate of reimbursement.

ROUTINE SERVICES

Expenses pertaining to utilization review of all patients, physical therapy and other remedial therapeutic services will be accepted and considered as routine services for rate

calculation.

Expenses pertaining to the services of a Behavior Health Specialist, who is licensed by the State of Rhode Island and is not eligible for direct reimbursement under the Rhode Island Medical Assistance program, will be considered routine services and accepted for rate calculation.

EDUCATIONAL ACTIVITIES

The cost of approved educational activities of full-time employees will be included as an allowable cost provided that such activities are directly related to improving adequate patient care or the administration of the facility. In addition, the activity must be formally organized by a recognized school or organization approved by the State. Educational activities do not cover nurse's aide training and competency evaluation expenditures as these expenditures are not reimbursable through the Medicaid Program.

PHYSICIANS' FEES

Reasonable fees which pertain to utilization review, medical director, employees physical examinations and services required by OBRA-87 are considered allowable costs.

CONFERENCE EXPENSES

Reasonable expenses related to attendance at meetings and conferences may be allowable subject to the following conditions:

a. The program offered is approved as one which has the purpose of maintaining or improving the quality of patient care or administration within a facility.

b. The State shall determine whether there is a direct relationship between the job responsibilities of the person in attendance and the subject matter covered.

c. Attendance to major out-of-state conferences will be limited to two such conferences with not more than one person attending.

MEDICINE CHEST SUPPLIES, TRANSPORTATION AND LAUNDRY EXPENSES

The per diem and interim per diem rates that are established include the reported expenses of nursing and medicine chest supplies, examples of which are, but not limited to, Appendix 'D'; transportation of patients who can be transported by auto to and from physician's office, dental services, medical laboratories and hospitals for outpatient treatment; as well as laundry expenses including personal laundry with the exception of dry cleaning costs; therefore, facilities must not charge Title XIX patients or their relatives for these services.

INSURANCE

Generally acceptable insurance coverage for business enterprises including the types listed below are reimbursable:

1. Liability Insurance
2. Malpractice Insurance
3. Worker's Compensation
4. Property Insurance

Payment of health and life insurance premiums which provide benefits to an employee or his/her beneficiary are considered fringe benefits and should be claimed as such by the provider. Premiums related to insurance on the lives of officers and key employees which name the provider as beneficiary are not allowable costs. If the individual or his estate are beneficiary, the premiums can be considered compensation to the individual and the cost would be allowable to the extent his/her total compensation is

reasonable.

Insurance costs applicable to transportation vehicles will be allowable to the extent of equivalent vehicle units permissible under the principles.

Mortgage insurance premiums are generally not an allowable cost. However, where the principal mortgagee specifically requires that the insurance be obtained as a prerequisite to completing financing arrangements and the insurance agreement stipulates that total proceeds must apply to the mortgage balance, then the premiums shall be reimbursable. The proceeds so applied will be construed as allowed depreciation taken for reimbursement purposes.

START-UP COSTS

"Start-up costs" are defined for the Rhode Island Medicaid Program as those costs incurred for the operation and maintenance of a facility for a period not to exceed six weeks prior to the admission of the first patient. Such costs would include administration and nursing salaries, heat, gas, electricity, insurance, employee training costs (excluding nurse's aide training and competency evaluation expenditures), repairs and maintenance and any other allowable costs incident to the operation of the facility, but not interest, depreciation and real estate and personal property taxes. In as much as start-up costs would relate to services to patients subsequently admitted to the facility, they are considered to be deferred charges and amortization of these charges will be allowed over a period of 60 months.

COST NOT RELATED TO PATIENT CARE

The following are examples of, but not limited to, items which are not recognized for

cost reimbursement purposes:

1. personal expenses,

2. items and services for which there is not legal obligation to pay,

3. business expense not related to patient care,

4. physician fees, prescription drugs and medications, as they are covered by means of a separate program,

5. reimbursed expenses,

6. costs of meals sold to visitors and employees,

7. costs of drugs, items and supplies sold to other patients,

8. cost of operation of a gift shop intended to produce a profit. Where expenses cannot be specifically identified the revenue derived will be used to reduce the total operating expenses of the facility.

9. expenses which exceed amounts under the prudent buyer concept,

10. accrued expenses not paid within 90 calendar days after close of the reporting period, except for bankruptcy proceedings, or at time of the audit, examples are but not limited to:

a. professional services including attorney and accounting fees,

b. unpaid compensation of employees, officers and directors owning stock in a closely-held corporation,

c. fringe benefits,

d. consultant fees,

e. suppliers and vendors,

f. trade association dues,

Any accrued expenses so disallowed will, however, be recognized when eventually paid by adjusting the costs of the year in which the expense was incurred.

11. State and Federal income taxes,

12. directory and display advertising or other means of advertising,

13. bad debts,

14. management fees,

15. expenses attributed to anti union activities as specified in H.I.M.-15,

16. excessive purchases of supplies when compared to previous years and years subsequent to base years,

17. employment agency fees/agency contract for purpose of recruitment,

18. costs of beepers,

19. costs of telephone in motor vehicles, and,

20. costs of nurse aide training and competency evaluations. The inclusion of cost such as those set forth in 1-20 above, which are not related to patient care may constitute a violation of General Laws Section 40-8.2-4, as well as other provisions of State and Federal law and may result in criminal and civil sanctions and possible exclusion from participation in the Medicaid Program.

The State reserves the right to make determinations of admissible and/or inadmissable costs in areas not specifically covered in the principles.

CONSTRUCTION COSTS

General

The Department of Health defines a construction project as "the total estimated cost of all elements or components of a functional facility submitted for cost reimbursement including equipment (whether purchased or leased) for providing services to nursing or personal care home patients, personnel, or the visiting public."

Any construction of a substantial nature is reviewed by the Health Services Council and must be approved by the licensing agency, the Department of Health.

Cost Basis for Medicaid Reimbursement Purposes

The basis of allowable depreciation shall be the actual historical costs but not in excess of the total project cost approved by the Department of Health.

Verification of Costs

Within a reasonable time after the completion of a project an audit will be conducted to determine whether the cost of construction is fairly presented and whether the project is in general compliance with the terms approved by the licensing agency.

Transactions Between Affiliated Parties

Where the contractor and provider are affiliated through common ownership, no profit add-on is permitted for cost reimbursement purposes.

SERVICE AND AFFILIATED ORGANIZATIONS

General

Any company or business entity which provides products and/or services to an affiliated nursing home or group of homes, where common ownership exists, must be reported to the Rate Setting Unit in order to meet reimbursement requirements.

Reporting Requirements

The report form must be filed for approval. Data required will include but not be

limited to:

a. explanation of the need for such an organization,

b. ownership interest and legal form of organization,

c. type of product or services to be rendered,

d. names of all affiliated facilities to be serviced.

Requests for approval must be filed prior to the end of the calendar year in which the service and/or affiliated organization commences operations. This will allow for a determination of whether or not charges from the related service company to the nursing facility will be allowed.

The State requires in addition to the BM-64, the following:

a. financial statements of the related service company,

b. tax returns if above statements are not available.

If centralized services such as accounting, purchasing, administration, etc., are involved, complete details regarding the allocation of charges must be provided.

Cost applicable to services, facilities and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. Costs include those actually incurred to which may be added reasonable handling and administrative charges. Profit add-on in the form of markups or by other means is not permitted nor acceptable for reimbursement under the Rhode Island Medical Assistance Program, Title XIX, Medicaid.

HOME OFFICE CHARGES

Long Term Care facilities sometimes operate through a central home office resulting in home office charges. Cost-related expenses may be reimbursable providing that said central home office is physically located within the State of Rhode Island and if they can satisfy the reasonable cost-related concept previously described and if they can demonstrate and document that central management, purchasing and accounting services were uniformly performed for all facilities. Home office cost-related expenses, if the above is satisfied, will be pro-rated to each facility and enterprise for which services are being provided. The central home office must prepare and file with the Rate Setting Unit a cost report annually, in an approved format showing line-cost and allocation to each facility or enterprise. Additionally each enterprise for which services are provided must be fully disclosed.

A central home office established on or after January 1, 1985 must obtain prior written approval from the Rate Setting Unit in order to qualify to have its allocated costs recognized for reimbursement.

In-State Central/Home Office

Cost will be allocated and reimbursed through the Management Related Expenses cost center and All Other Expenses cost center.

Out-of-State Central/Home Office

Charges will be recognized to the extent of the lesser of reported reasonable costs of central home office plus costs in Account No.'s 7421-Other Administrative Salaries, No. 7435-Accounting and Auditing Fees or the average allowable amount for facilities of like size and licensure for Account No.'s 7421-Other Administrative Salaries, No 7435-Computerized Payroll and Data Processing Charges and No. 7436-Accounting and

Auditing Fees. The acceptable amount will be allowed in the Management Related Expenses cost center.

Changes in Bed Capacity

Facilities in which the bed capacity is either substantially increased or decreased will be re-evaluated insofar as the reimbursement rate, and such change in rate, if at all, will be made retroactive to the date in which such change in bed capacity was authorized by the licensing authority.

Excess Bed Capacity

Per diem rates will be based upon the actual percentage occupancy of the facility's total licensed bed capacity in the base year or 98 percent of the statewide average occupancy rate in the prior calendar year, whichever is greater. For those facilities being licensed for only a portion of their potential bed complement, the 98 percent of the statewide average occupancy rate of the prior calendar year will be based on the available bed days of the portion licensed. However, expenses relating to the physical plant of such facilities such as, but not limited to the following, interest, depreciation and real estate and personal property taxes will be allowed only as they apply to the licensed portion on a per diem predicated upon actual occupancy or 98 percent of the statewide average occupancy rate of the prior calendar year, of total potential bed complement of the facility, whichever is greater.

Transactions which Reduce Reported Cost of Patient Care

Operations may result in the receipt of revenue from sources other than the direct care of patients. Where it is determined that these amounts are in fact, reductions of previously incurred costs or are added revenue associated with the business purposes of

the facility, such amounts must be offset against operating costs. For example, sale of meals, interest income, sale of supplies, etc., should be used to reduce costs.

Refunds, Discounts, and Allowances

Refunds, discounts and allowances received on purchased goods or services must be netted against the purchase price.

Quality of Care And Cost Incentives

The Department will pay a differential reimbursement rate of $ 200.00 to providers of service who provide ventilator beds at their facilities. This rate will be in addition to the per diem rate assigned for actual days a resident requires this service, and the rate will only apply to those resident days that are supported by a physician order. This amount will be limited to a maximum of ten (10) beds on a statewide basis and a facility must meet the following criteria:

- The facility must be Medicare-certified.
- The facility must have a minimum of five (5) ventilator beds, and
- The facility must have a licensed Respiratory Therapist on staff or under contract.

The facility must request and receive approval for the differential reimbursement rate in writing from the Rate Setting Unit.

APPENDIX 'A'

BASE YEAR AND AUDIT SCHEDULING

Note: This base year and audit schedule will be utilized for the Management Related and All Other Expenses Cost Centers until September 30, 2005. As of October 1, 2005, this Appendix will no longer be required.

The Schedule for Base Year Calendar Year 1991 and Subsequent Base Years and For Scheduling Base Year Audits will be determined As Follows:

1. Participating Nursing Facilities will be grouped into one level of care category and listed in numerical sequence by license number.

2. During the first audit schedule year and every third year thereafter, the first and each subsequent third listed facility will be scheduled for audit.

3. During the second audit schedule year and every third year thereafter, the second and each subsequent third listed facility will be scheduled for audit.

4. During the third audit schedule year and every third year thereafter, the third and each subsequent third listed facility will be scheduled for audit.

5. Newly constructed facilities and facilities that change ownership will be audited after the completion of six months of operations. Thereafter, these facilities will be scheduled to be audited by adding them to the original listing of facilities by license number sequence.

6. Facilities previously licensed but non-participating that subsequently become participating

in the Rhode Island Medicaid Program will be audited after the completion of six months of operation. Thereafter, these facilities will be scheduled to be audited by adding them to the last

appearing facility license number at the time of certification.

7. Multiple facilities that are operated, managed and/or controlled by an In-State Central/Home Office or an In-State Management Group will be assigned the same base year and will be scheduled for audit by grouping the facilities. The lowest licensed numbered facility will determine the audit scheduling process by applying provisions 2 through 4 above. Additional facilities serviced by the In-State Central/Home Office will not alter base years and/or audit scheduling of its grouping.

APPENDIX 'B'

USEFUL LIFE OF LAND IMPROVEMENTS, BUILDINGS, AND FIXED EQUIPMENT

LAND IMPROVEMENTS	YEARS
Fencing	
Brick or stone	**25**
Chain link	15
Wire	5
Wood	8
Flagpole	20
Paving (including roadways, walks, and parking)	
Asphalt	15
Concrete	20
Gravel	5
Retaining wall	20
Shrubs, lawns, and trees	10
Sign	12
Turf, artificial	5
Underground sewer and water lines	30
Yard lighting	15
BUILDINGS	
Boiler house	25
Garage	
Masonry	25
Wood frame	15
Masonry, reinforced concrete frame	40
Masonry, steel frame, fireproofed	40
Masonry, steel frame not fireproofed	30
Masonry, wood frame	25
Multilevel parking structure, masonry	25
Residence	
Masonry	25
Wood frame	25
Storage building	20

FIXED EQUIPMENT	YEARS
Building Services Equipment:	
Electric Lighting and	
Power feed wiring	20
Conduit and wiring	20
Fixtures	10
Transformer	20
Switch gear	20
Elevator	
Dumbwaiter	20
Freight	20
Passenger, high-speed automatic	20
Passenger, other	20
Central television antenna system	15
Central clock system	20
Heating, ventilating, and air conditioning	20
Air conditioning system, all equipment and units	
Large-over 20 tons	15
Medium-5 to 10 tons	10
Small-under 5 tons	8
Boiler	20
Compressor, air	15
Condensate tank	20
Condenser	15
Controls	20
Cooler and dehumidifier	10
Cooling tower	
Wood	15
Metal	15
Duct work	20
Fan, air handling and ventilating	15
Filter	15
Furnace, domestic type	15
Incinerator, indoor	20

APPENDIX 'B'

USEFUL LIFE OF LAND IMPROVEMENTS,
BUILDINGS, AND FIXED EQUIPMENT

LAND IMPROVEMENTS	YEARS
Oil storage tank	20
Piping	25
Precipitator	15
Pump	15
Radiator, cast iron	30
Radiator, finned tube	20
Unit heater	10
Nurse call system	15
Oxygen, gas, air piping	25
Paging system	15
Plumbing, composite	25
Fixtures	20
Piping	25
Pump	15
Water heater, commercial	15
Water storage tank	20
Sprinkler and fire	
Protection system	25
Fire alarm system	20
Fire pump	20
Sprinkler system	25
Tank and tower	25

FIXED EQUIPMENT	YEARS
Sewerage, composite	30
Piping	25
Sump pump and	
sewerage ejector	10
Telephone system	20
Vacuum cleaning system	15
Other Fixed Equipment	
Built-in bench, bin	
cabinet, counter,	
shelving	20
Conveying system	15
Generator set	20
Hood, fume	20
Sink and drain board	20
Sterilizer, built-in	20

APPENDIX 'B'

USEFUL LIVES OF INDIVIDUAL ITEMS OF MAJOR MOVABLE EQUIPMENT

Item	Years	Item	Years
Accelerator	8	Block, butcher or meat	10
Accounting/Bookkeeping machine	10	Blood chemical analyzer, auto	8
Adding machine	10	Blood cell counter	10
Air conditioner (window)	8	Blood gas analyzer	10
Analyzer, gas	10	Blood gas appar., volumetric	10
Analyzer, oxygen	10	Blood warmer	10
Ambulance	4	Blood warmer coil	10
Amplifier	10	Boiler, copper	20
Anesthesia unit	12	Bookcase, metal	20
Ankle exerciser	15	Bottle washer	10
Apparatus		Breathing unit, pos pressure	8
Anesthesia	12	Boiler	15
Resuscitating	10	Buffer, electric	10
Blood transfusion	15	Bulletin board	10
Bone Surgery	10	Burnisher, silverware	15
Audiometer	10	Cabinet, bedside	15
Autoclave	20	Cabinet, metal or wood	20
Automobile, delivery	4	Cabinet, solution	20
Automobile, passenger	4	Calculator	10
Autoscaler, ionic	10	Camera	8
Aspirator	10	Camera, TV monitoring, color or black and white	8
Balance	15	Camera, videotape, color or black and white	10
Basal metabolism unit	8	Canopy, ventilating, ironer	15
Bassinet	15	Capsule machine	15
Bassinet, heated	10	Cardioscope	8
Bath paraffin	15	Carpeting	5
Bath, serological	15	Cart, food/tray, heat-refrig.	10
Bath, water, laboratory	15	Cash register	10
Bed, electric	15	Cassett Changer	15
Bed, manual	15	Cautery Unit	10
Bench, metal or wood	15	Central processing unit	10
Bin, metal or wood	20	Centrifuge	15
Biochem anal unit, micro	8	Chair, dental	15
Blanket, drier	15	Chair, executive	15
Blanket warmer	15	Chair, metal or wood	20
Bleach tank	15		

APPENDIX 'B'

USEFUL LIVES OF INDIVIDUAL ITEMS OF MAJOR MOVABLE EQUIPMENT

Item	Years	Item	Years
Chair, specialist	15	Data printing unit	8
Chair, wheel	15	Data storage unit, mechanical	10
Chart, rack	20	Data storage unit, nonmchnicl	20
Check signer	10	Data tape processing unit, incl.	
Chromatograph, gas	10	controller, drive, tape deck	10
Clock	15	Decalcifier	10
Clths lckr,fgls or metal	20	Defibrillator	8
Clths lckr, lmnte or wd	12	Densitometer, recording	8
Cobalt unit	8	Dermatome	10
Coffee grinder	10	Desk, metal or wood	20
Cold pack unit, floor	10	Diathermal apparatus	10
Collator, electric	10	Diathermy unit	10
Collector, silver autom	10	Dictating equipment	10
Colorimeter	10	Dilutor	15
Compactor, waste	10	Dish Sterilizer	10
Compressor, air	15	Dishwasher	10
Conductivity tester	10	Disinfector	15
Conveyer, tray	15	Dispenser, alcohol	15
Conveying sysetm, laundry	15	Dispenser, butter, refrigerated	10
Cooker, pressure, food	10	Dispenser, milk or cream	10
Cooker, starch	20	Distilling apparatus	20
Cooler, walk-in frstndng	20	Dresser	20
Cooler, water	10	Drier, clothes	10
Counter, food service	15	Drier, hair	10
Croupette	10	Drier, sonic	10
Crusher, syringes	10	Drill press	20
Cryosurgical unit	10	Drying oven, paint shop	12
Cryostat	10	Duplicator	10
Curtain stretcher	15	Electrocardiograph	8
Cutter, cloth, electric	10	Electroencephalograph	8
Cutter, food	10	Electromyograph	8
Cystometer	10	Electrophoresis unit	8
Cystoscope	10	Electrosurgical unit	8
Dampener	15	Ether-suction unit	10
Data card processing unit,		Evacuator	15
including keypunch, verifr,		Exercise apparatus	15
reader, sorter	10	Extractor, fruit juice	10

APPENDIX 'B'

USEFUL LIVES OF INDIVIDUAL ITEMS OF MAJOR MOVABLE EQUIPMENT

Item	Years	Item	Years
Extractor, laundry	15	Incubator, nursery	15
Fire extinguisher	20	Indicator, remote	10
Floor scrubbing machine	8	Infusion pump	10
Floor waxing machine	8	Inhalator	10
Flowmeter	10	Intercom	15
Fluorimeter	10	Ironer, flatwork	15
Fluoroscope	10	Ironing board	15
Folder, flatwork	15	Isotope equipment	8
Food chopper	15	Jointer/planter, electric	20
Frame, turning	15	Kettle, steam jacketed	15
Fryer, deep fat	10	Kickbucket	10
Furnace, laboratory	15	Kidney dialyzer	8
Glove conditioner	10	Kiln	15
Glove drier	10	Kymograph	10
Glove powdering machine	10	Ladder	10
Glove tester	10	Lamp, deep therapy	10
Graphotype	15	Lamp, emergency	10
Griddle	12	Lamp, infrared	10
Grinder, bench	15	Lamp, mercury quartz	10
Grinder, food waste	15	Lamp, microscope	10
Hamper	5	Laryngoscope	10
Heart-Lung system	8	Lathe	12
Hemoglobinometer	10	Lawn mower, power	4
Hemodialysis unit	10	Library furnishings	20
Homogenizer	15	Lifter, patient	15
Hot plate	10	Light, delivery	15
Humidifier	10	Light, examining	10
Hydrotherapy equipment	15	Light, operating	15
Hyfrecator	10	Light, portable, emergency	15
Hypothermia apparatus	12	Linen cart	15
Ice cream freeze	10	Linen drier	20
Ice cream storage cabinet	10	Linen marker	15
Ice cube making, equipment	10	Linen press	20
Illumntr unit, multifilm	15	Linen table	15
Illuminator unit, single	20	Linen washer	15
Imprinter, embossed plate	10	Mailing machine	10
Incubator, laboratory	15	Mannequin	10

APPENDIX 'B'
USEFUL LIVES OF INDIVIDUAL ITEMS OF MAJOR MOVABLE EQUIPMENT

Item	Years
Marking machine	15
Mattress	8
Meat chopper	10
Meter, pH	10
Microfilm unit	10
Microscope	10
Microprojector	15
Microtome	12
Mixer, commercial type	15
Model, anatomical	10
Monitor, TV	10
Mop truck	10
Narcotic safe	25
Nebulizer	10
Operating stool	20
Ophthalmoscope	10
Oscilloscope	12
Osmometer	10
Otoscope	10
Ottoman	10
Oven, baking	15
Oven, microwave	10
Oven, paraffin	10
Oven, roasting	15
Oven, sterilizing	10
Oximeter	10
Oxygen tnk, mtr, and truck	8
Pacemaker, cardiac	8
Patient monitoring equipt	8
Paint spray booth	15
Paint spraying machine	10
Paper baler	20
Parallel bars	15
Peeler, vegetable, elctrc	15
Photocoagulator	10
Photocopier	10
Photography apparatus, gross pathology	15
Photometer	8
Physician's in-and-out register, portable	15
Piano	20
Pipette, automatic	10
Planer and shaper, electric	20
Polisher, floor	8
Polishing and buffing machine	8
Power supply	10
Press, laundry	15
Proctoscope	10
Projection machine	15
Projector, slide	20
Prothrombin timer, automated	10
Pulmonary function equipment	10
Pump, vacuum or pressure	10
Rack, pot or pan	20
Radiation counter	8
Radiation meter	10
Radioactive source, cobalt	5
Radiographic-fluorosc. comb.	8
Range, household	15
Recorder, laboratory	10
Refractometer	10
Refrigerator, blood bank	10
Refrigerator, commercial type	10
Remote control receiver	10
Resuscitator	10
Rinser, sonic	10
Safe	25
Sanitizer	20
Saw, autopsy	10
Saw, bench, electric	20

APPENDIX 'B'

USEFUL LIVES OF INDIVIDUAL ITEMS OF MAJOR MOVABLE EQUIPMENT

Item	Years	Item	Years
Saw, surgical, electric	10	Stretcher	15
Saw, neurosurgery	10	Suction pump	10
Scale, laundry, platform	20	Table, anesthetic	15
Scale, laundry, movable	12	Table, autopsy	20
Scale, postal	10	Table, examining	15
Scanner, isotope	8	Table, metal	20
Scintillation scaler	8	Table, obstetrical	20
Seriograph, automatic	10	Table, operating	20
Sewing machine	15	Table, refrigerated	10
Shaking machine	10	Table, therapy	15
Sharpnr, microtome knife	12	Table, wood	12
Shears, squaring, floor	12	Tank, hot water	15
Shelving, portble, steel	20	Tank, paraffin	15
Shoulder wheel	20	Tank, soap	15
Sigmoidoscope	10	Television receiver	8
Skeleton	10	Tent, oxygen	8
Slicer, bread	10	Thermometer, electronic	10
Slide stainer, lab	10	Time recording equipment	10
Slit lamp	10	Tissue processor	10
Snow blower	8	Titrator, automatic	10
Soap dispenser	10	Toaster, commercial type	10
Spectroscope	10	Traction unit	10
Spectrophotometer	8	Tractor	10
Sphygmomanometer	10	Transcribing equipment	10
Stall bars	20	Treadmill, electric	8
Stamp machine	10	Truck, hot food	10
Stand, irrigating	20	Tube tester	10
Stapler, electric or air	10	Tumbler	15
Steam pack equipment	12	Typewriter, electric	5
Steamer, vegetable	10	Typewriter, manual	8
Stencil machine	10	Ultrasonic cleaner	10
Sterilizer, movable	20	Urn, coffee	10
Stethophone	10	Urn, milk	10
Stimulator, muscle	10	Vacuum cleaner	10
Stirrer	10	Vending machine	10
Stock pot	10	Venetian blind	10
Stool, metal or wood	20	Ventilating fan	15

APPENDIX 'B'

USEFUL LIVES OF INDIVIDUAL ITEMS OF MAJOR MOVABLE EQUIPMENT

(Cont'd)

Item	Years
Vial filler	10
Vibrator	10
Waffle iron, commercial type	8
Warmer, dish	10
Warmer, food	10
Washing mach, commercial type	10
Waste receptacle, metal	10
Water cooler bottle type or function type	10
Water purifier or softener	12
Wheelchair	15
X-ray developing tank	15
X-ray film drier	8
X-ray film processor	8
X-ray image intensifier	8
X-ray unit, deep therapy	8
X-ray unit, mobile	8
X-ray unit, superficial therapy	8

APPENDIX 'C'

ADMINISTRATORS' COMPENSATION

NO. BEDS	Max Salary Allowance
1-75	$59,947
76	$61,216
77	$61,524
78	$61,830
79	$62,139
80	$62,442
81	$62,753
82	$63,050
83	$63,360
84	$63,664
85	$64,304
86	$64,937
87	$65,574
88	$66,211
89	$66,850
90	$67,488
91	$68,119
92	$68,759
93	$69,395
94	$70,032
95	$70,663
96	$71,303
97	$71,945
98	$72,583
99	$73,214
100	$73,856
Each Additional Bed	$285

ASSISTANT ADMINISTRATORS WILL BE LIMITED TO THE LOWER OF ACTUAL SALARY PAID OR 75% OF THE ADMINISTRATORS SALARY ALLOWANCE.

APPENDIX 'D'

ROUTINE SERVICE - NURSING AND MEDICINE CHEST SUPPLIES

Items of service and supplies which have been identified and defined as routine services and allowable in the per diem rate are listed but not limited to those listed below for Nursing Facilities.

ABD pads
A & D ointment
Adrenal I.M.
Air mattresses
Air P.R. mattresses
Airway - oral
Alcohol
Alcohol plasters
Alcohol sponges
Antacid suspensions
Antipruitic oil
Applicators, cotton tipped
Applicators, swab-eez
Aquamatic K pads (water-heated pad)
Arm slings
Asepto syringes
Adhesive tape
Baby powder
Bandages
Bandages - elastic or cohesive
Band-aids
Basins
Bed frame equipment (for certain immobilized bed patients)
Bed rails
Bedpan, fracture
Bedpan, regular
Bedside tissues
Benzoin, aerosol
Bibs
Bottle, specimen
Canes
Cannula-nasal
Cascara (1 oz.)
Catheter, indwelling
Catheter plugs
Catheter tray
Catheters (any size)
Colostomy bags
Composite pads
Cotton balls
Crutches
"Customized" crutches, canes, and wheelchairs
Decubitus ulcer pads
Deodorants
Disposable underpads
Donuts
Douche bags
Drain tubing
Drainage bags
Drainage sets
Drainage tubes
Dressing tray
Dressings (all)
Drugs, nonlegend
Drugs, stock; excluding insulin

Enema can
Enema-Fleets
Enema-retention
Enema soap
Enema supplies
Enema unit
Enemas
Eye pads
Feeding tubes
Female urinal
Flotation mattress
Flotation pads and/or turning frames

ROUTINE SERVICE - NURSING AND MEDICINE CHEST SUPPLIES
(Cont'd)

Folding foot cradle

Gastric feeding unit
Gauze sponges
Gloves, unsterile and sterile
Gowns, hospital
Green soap

Hand, feeding
Heat cradle
Heating pads
Heel protector
Hot pack machine

Ice bags
Incontinency care
Incontinency pads and pants
Infusion arm boards
Inhalation therapy supplies
Aerosol Inhalators, self contained
Aerosol (other types)
Nasal catheter insertion and tube
Nebulizer and replacement kit
Steam vaporizer
Intermittent positive pressure breathing machines (I.P.P.B.)
Invalid ring
Irrigation bulbs
Irrigation trays
I.V. trays

Jelly-lubricating
Keolin and pectin solution
Linens, extra
Lotion, soap and oil

Male urinal
Massages (by nurses)
Medical social services
Medicine dropper
Methiolate aerosol
Milk of magnesia
Mineral oil
Mouthwashes

Nasal cannula
Nasal catheter
Nasal gastric tubes
Nasal tube feeding
Needles (various sizes)
Needles-hypodermic-scalp, vein
Non-allergic tape
Nursing services (all) regardless of level, including the administration of oxygen and restor. nursing care
Nrsng suppl./dressings (other than items of prsnl comfrt/ cosmetics)

Ointment (non-prescription), skin
Overhead trapeze equipment
Oxygen equipment (such as IPPB machines and oxygen tents)
Oxygen mask
Oxygen tank for emergencies

Pads
Peroxide
Pharmaceuticals, non-prescription
Pitcher
Plastic bib
Pumps (aspiration and suction)
Restraints
Room and Board
Sand bags
Scalpel
Sheepskin
Special diets
Specimen cups

ROUTINE SERVICE - NURSING AND MEDICINE CHEST SUPPLIES
(Cont'd)

Sponges
Sterile pads
Stomach tubes
Suction catheter
Suction machines
Suction tube
Suppositories
Surgical dressings (including sterile sponges)
Surgical pads
Surgical tape
Suture removal kit
Suture trays
Syringes (all sizes)
Syringes, disposable

Tape for laboratory tests
Tape (non-allergic or butterfly)
Testing sets and refills
Tongue depressors
Tracheostomy sponges
Tray service
Tubing - I.V. trays
Blood infusion set
I.V. tubing

Underpads
Urinary drainage tubs
Urinary tube and bottle
Urological solutions

Walkers
Water pitchers
Wheelchairs

CHART OF ACCOUNTS WITH EXPLANATIONS IN SUMMARY FORM **Appendix 'E'**

ACCOUNT NUMBER	DEPARTMENT AND ACCOUNT	ILLUSTRATIONS OF ITEMS
		INCOME
0300	GROSS INCOME	
0300A	Room and Board - Private-Paying Patients	
0300B	Room and Board - Federal Medicare Patients	
0300C	Room and Board - State Medicaid Patients	
0300D	Room and Board - Veteran Patients	
0300E	Room and Board - Blue Cross Patients	
0300F	Room and Board - Employees	
0300G	Retrospective Adjustment	
0301	Sale of Drugs and Supplies	
0302	Laboratory Fee Income	
0303A	Physical Therapy - Federal Medicare	
0303B	Physical Therapy - Private-Paying Patients	
0303C	Physical Therapy - Other Patients	
0303D	Other Therapeutic Services - Federal Medicare	
0303E	Other Therapeutic Services - Private Patients	
0303F	Other Therapeutic Services - Other Patients	
0304	Utilization Review - Medicare	
0305	Laundry Income	
0306	Guest and Employee Meals	
0307	Vending Machine Income	
0308	Income from Empty Beds	
0309	Rent Income	
0310	Interest Income	

CHART OF ACCOUNTS WITH EXPLANATIONS IN SUMMARY FORM Appendix 'E'
(cont'd)

ACCOUNT NUMBER	DEPARTMENT AND ACCOUNT	ILLUSTRATIONS OF ITEMS
0311	Ancillary Service Income	
0312	Meals on Wheels Program	
0313	Day Care Program	
0314	Other Income (Specify)	
0315	Nurse's Aide Training/Competency Evaluation	
		EXPENSES
	PASS THROUGH ITEMS	
1451	Real Estate Taxes	Taxes on Real Est./property owned by facility
1451A	Personal Property Taxes	
1451B	Fire Tax	
2512	Fuel	
2513	Gas	
2514	Electricity	
5442	Insurance	Premiums for all institutional insurance
8470	Health Care Provider Assessment	
	OTHER PROPERTY RELATED	
3452	Interest	Interest on mortgages, loans or notes payable including working capital loans
3453	Rent/Lease	Rent on property leased by facility
3453A	Lease of Equipment	Lease payments
3454	Amortization of Leasehold Improvements	Pro rata share of costs of changes made on bldg leased for business

CHART OF ACCOUNTS WITH EXPLANATIONS IN SUMMARY FORM Appendix 'E'
(cont'd)

ACCOUNT NUMBER	DEPARTMENT AND ACCOUNT	ILLUSTRATIONS OF ITEMS EXPENSES
	OTHER PROPERTY RELATED (Cont'd)	
3455	Building Depreciation	Annual share of estimated depreciation on building
3455A	Building Improvements Depreciation	
3457	Equipment Depreciation	Furniture, fixtures and equipment
3466	Motor Vehicles Depreciation	Cars, trucks, etc.
	DIRECT LABOR	
4431	Health Care Plan - Employer's Share	Employer's share of health insurance coverage
4432	Other Employee Fringe Ben.	
4440	Payroll Taxes	Employer's share of social security taxes and of Federal and State Unemployment & Disability Insurance
4442A	Insurance-Workers' Compensation	
4511	Maintenance Salaries	Engineers, heating plant employees, watchman, outside maintenance
4521	Salaries	Dieticians, chefs, cooks, dishwashers, helpers
4524	Purchased Dietary Services	Outside services
4531	Laundry Salaries	Laundryman or woman, ironers, seamstress
4538	Purchased Services	Expenses for outside commercial laundry services, linen hire
4541	Housekeeping Salaries	Housekeepers, maids, porters
4548	Housekeeping Purchased Services	
4600	Director of Nurses	

CHART OF ACCOUNTS WITH EXPLANATIONS IN SUMMARY FORM Appendix 'E'
(cont'd)

ACCOUNT NUMBER	DEPARTMENT AND ACCOUNT	ILLUSTRATIONS OF ITEMS
	EXPENSES	
	DIRECT LABOR (Cont'd)	
4601	Salaries - R.N.	
4611	Salaries - L.P.N.	
4615A	Physical Therapist - Medicare	Title XVIII-Medicare
4615B	Physical Therapist - Medicaid	Title XIX-Medicaid
4615C	Physical Therapist - Private-Paying	Private-Paying patients
4615D	Physical Therapist - Medicaid other States	
4621	Salaries - Aides & Others	Unlicensed Practical Nurses, Nurses' Aides, Attendant Orderlies
4622A	Purchased Services of R.N.'s	
4622B	Purchased Services of LPN's	
4622C	Purchased Services of N.A.'s	
4715A	Other Therapeutic Services/Medicare	Salary or purchased services
4715B	Other Therapeutic Services/RI Medicaid	Salary or purchased services
4715C	Other Therapeutic Services/Private/Other	Salary or purchased services
4728A	Other Labor-Salaries, Fees	
6415	Medical Director Salary/Fee	
6711	Physician’s Salaries/Fees	
6713	Social Worker Salary/Fee	
6751	Recreational Activity Salaries/Fees	

ALL OTHER

5425	**Office Supplies & Printing**	**Stationary, postage, printing, subscriptions & all supplies**
5426	Communications	Telephone, telegraph
5427	Travel-Motor Vehicle	Cost of operating automobile in connection with administrative duties
5428	Conventions, Meetings	Registrations, travel and other
5428A	Education & Seminars	Registrations, travel and other
5429	Advertising & Public Relations	Advertisements, brochures and all promotional expenses
5429A	Advertising - Help Wanted	Advertisements for Aides, Nurses, etc.
5430	Licenses & Dues	Institutional license fees, personal & Institutional membership dues, trade publications, etc.
5433	Home Office/Central Office	Portion other than labor and payroll-related expenses
5443	State Franchise Taxes	Corporation or Owners State Tax
		5449 Miscellaneous
5515	Water & Sewerage	
5516	Maintenance Supplies	Ladders, lumber, paint, working tools
5518	Maintenance Purchased Services and Repairs	Contract fees for repairs and services, window washing, cleaning floors, etc.
5522	Raw Food	Cost of all food purchased.
5529	Dietary Supplies	Replacement dishes, kitchen utensils, soap and detergents used in kitchen
5532	Linens & Bedding Supplies	Sheets, mattresses, pillows, towels, wash cloths (replacement only)
5539	Laundry Supplies	Laundry soap, bleaches, starch
5549	Housekeeping Supplies	Brooms, brushes, insecticides, polish, soap
5629	Nursing Supplies	Adhesive, dressings, gauze, thermometers, alcohol,

		powder, and other Medical Supplies as IV & Sc bottle needles & syringes
5629A	-Medicare	
5629B	-RI Medicaid	
5629C	-Private Pay & Other	
5629D	-Medicaid Other States	
5629E	-House	
5724	Pharmacy Supplies	Over-the-counter medicines & drugs such as aspirin, vitamins, etc.
5724A	-Medicare	
5724B	-RI Medicaid	
5724C	-Private Pay & Other	
5724D	-Medicaid Other States	
5724E	-House	
5728	Other Expenses	Other supplies not reported elsewhere-specify
5758	Recreational Supplies	Ceramics, handicrafts, movies, leather
5759	Other	

MANAGEMENT RELATED

7411	Administrator (Other than officers/owners)	Person responsible for admin. (no officers/owners)
7412	Officers/Owners Salaries	Compensation paid to officer/owner of the facility
7421	Other Administrative Salaries	Accounting and clerical personnel
7431	Health Care Plan (Employer's Share)	
7432	Other Employee Fringe Benefits	
7433	Home Office/Central Services	Home off., ctl. mgt portion attributable to labor and payroll expenses
7435	Computerized Payroll & Data Processing Charges	
7436	Accounting and Auditing Fees	
7437	Legal Services	

7440	Payroll Taxes
7442A	Insurance (Worker's Compensation)
7444A	Utilization Review Medicaid Title XIX
7449A	Miscellaneous Management Related
7523	Consultant Fees - Dietary
7712	Pharmacist Salary or Fees

C.O.B.R.A. REEVALUATION MULTIPLIER **APPENDIX "F"**

ASSET VALUES IN ACCODANCE WITH THE PROVISIONS OF C.O.B.R.A.
THE LESSER OF 50% OF THE DODGE CONST. INDEX OR 50% OF THE C.P.I.

YR END	DODGE CONST. INDEX		CPI - U INDEX		1/2 OF LOWER
	GENERAL	MULTIPLIER	ALL ITEMS	MULTIPLIER	
1960	412.00	8.19	29.80	7.08	3.54
1961	417.40	8.10	30.00	7.04	3.52
1962	427.00	7.94	30.40	6.96	3.48
1963	433.90	7.83	30.90	6.87	3.43
1964	436.10	7.79	31.20	6.81	3.41
1965	440.20	7.73	31.80	6.70	3.35
1966	446.90	7.63	32.90	6.51	3.26
1967	470.50	7.30	33.90	6.35	3.17
1968	477.90	7.20	35.50	6.11	3.05
1969	505.40	6.86	37.70	5.81	2.90
1970	540.80	6.48	39.80	5.56	2.78
1971	571.20	6.19	41.10	5.41	2.71
1972	635.00	5.67	42.50	5.27	2.63
1973	713.40	5.15	46.20	4.92	2.46
1974	806.20	4.68	51.90	4.49	2.25
1975	867.60	4.42	55.50	4.27	2.13
1976	920.30	4.22	58.20	4.12	2.06
1977	1,000.00	3.96	62.10	3.92	1.96
1978	1,061.50	3.79	67.70	3.68	1.84
1979	1,099.70	3.69	76.70	3.36	1.68
1980	1,165.30	3.54	86.30	3.10	1.55
1981	1,313.50	3.26	94.00	2.93	1.46
1982	1,347.70	3.20	97.60	2.86	1.43
1983	1,393.30	3.13	101.30	2.79	1.39
1984	1,455.10	3.04	105.30	2.72	1.36
1985	1,508.90	2.96	109.30	2.66	1.33
1986	1,558.00	2.90	110.50	2.64	1.32
1987	1,611.50	2.84	115.40	2.57	1.29
1988	1665.00	2.78	120.50	2.50	1.25
1989	1720.00	2.72	126.10	2.44	1.22
1990	1785.00	2.66	133.80	2.36	1.18
1991	1,855.00	2.60	137.90	2.31	1.16
1992	1910.00	2.55	141.90	2.28	1.14
1993	1975.00	2.50	145.90	2.24	1.12
1994	2055.00	2.44	149.70	2.21	1.11
1995	2120.00	2.40	153.50	2.18	1.09
1996	2240.00	2.32	158.60	2.14	1.07
1997	2310.00	2.28	161.30	2.12	1.06
1998	2400.00	2.23	163.90	2.11	1.05
1999	2525.00	2.17	168.30	2.08	1.04
2000	2630.00	2.13	174.00	2.04	1.02
2001	2705.00	2.10	176.00	2.03	1.01
2002	2826.00	2.05	177.70	2.02	1.01
2003	2963.00	2.00	181.30	2.00	1.00

N.B.
Data for Dodge Construction Index for calendar years 1988 thru 2003 are

Estimates. Date for Consumer Price Index thru calendar year 2003 is actual.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HUMAN SERVICES

THE AIME J. FORAND BUILDING

600 NEW LONDON AVENUE

CRANSTON, RI 02920

PRINCIPLES OF REIMBURSEMENT

FOR

INTERMEDIATE CARE FACILITIES – MENTALLY RETARDED

EFFECTIVE OCTOBER 1, 2003

PRINCIPLES OF REIMBURSEMENT

MEDICAID
PRINCIPLES OF REIMBURSEMENT
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PRINCIPLES OF REIMBURSEMENT

APPLICABLE FEDERAL AND STATE LAWS

Legal Basis for Program

The Rhode Island Medical Assistance Program was established on July 1, 1966, under the provision of Title XIX of the Social Security Act as amended by Public Law 89-97 which was enacted by the Congress on July 30, 1965. The enabling State Legislation is to be found in Title 40, Chapter 8 of the Rhode Island General Laws, 1956, as amended.

The Power of the Director

Rhode Island General Laws 40-8-13 provides that the Director of the Department of Human Services, shall make and promulgate rules, regulations, and fee schedules, for the proper administration of the Medical Assistance Program, and to make the Department's State Plan for Medical Assistance conform to the provisions of the Federal Social Security Act.

Penalties for Misrepresentation or Fraudulent Acts

Penalties for misrepresentation or fraudulent acts involving this program are covered by both Section 1909 (a) of the Social Security Act, and Sections 11-41-3, 11-41-4, 40-8.2-3, 40-8.2-4 and 40-8.2-7 of the Rhode Island General Laws and any other applicable statutes. These criminal penalties are in addition to civil actions for damages, recoveries of overpayments, injunctions to prevent continuation of conduct in violation of Chapter 40-8.2, as well as suspension or debarment from participation in the program by state or federal authorities.

Records Retention as Provided For By the Statute of Limitations (12-12-17)

Each provider of ICF-MR services participating in the Title XIX Medical Assistance Program in accordance with the provisions of these Principles of Reimbursement will maintain within the State of Rhode Island all original records or hard copies of records and data necessary to support the accuracy of the entries on the annual Cost Report. However, original invoices, canceled

checks, contracts, minutes of board of directors meetings and any other material used in the preparation of the annual cost report must be retained in Rhode Island for at least ten (10) years following the month in which the cost report to which the materials apply is filed with the State Agency as required by the Statute of Limitation. Each provider will make available upon request such records and all other pertinent records to representatives of the State Agency, representatives of the Federal Department of Health and Human Services, and the State's Medicaid Fraud Unit within the State's Attorney General Office.

The State Agency will maintain all cost reports submitted by providers and all audit reports prepared by the Agency for at least ten (10) years after the month in which the cost report was filed by the provider or at least ten (10) years after the month in which the audit was conducted.

These Principles of Reimbursement are implemented in accordance with the appropriate provisions of the State's Administrative Procedures Act.

The State will pay to participating providers of ICF-MR services who furnish services in accordance with the requirements of the Principles of Reimbursement the amount determined for services furnished by the provider under said Principles of Reimbursement.

If an overpayment to a participating provider of ICF-MR services is identified, repayment will either be made by direct reimbursement or by offsetting future payments to the provider. Such repayment may include interest charges on the overpayment amount as provided for by Section 40-8.2-22 of the Rhode Island General Laws.

GENERAL

Reporting

Reasonable Costs

The provision of ICF-MR Services to Medicaid recipients is provided only to those individuals who are eligible for these services in accordance with Medicaid regulations relating to resource and income. Consequently, the cost of services for those individuals with limited income and resources must be reasonable. The Department of Human Services shall have the discretion to determine through its review of submitted costs, and in accordance with these principles, what constitutes reasonable and allowable cost.

Not all reasonable and allowable costs must be reimbursed. Reimbursement rates will be reasonable and adequate to meet costs that must be incurred by economically operated nursing facilities to provide services in conformance with state and federal laws, regulations, and quality and safety standards. Reasonable costs shall mean those costs of an individual facilities for items, goods and services which, when compared, will not exceed the costs of like items, goods and services of comparable facilities in license and size. Reasonable costs include the ordinary, necessary and proper costs of providing acceptable health care subject to the regulations and limits contained herein.

Participants in the Medicaid program are expected to establish operating practices which assure that costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. Where it is determined that reported costs exceed those levels and in the absence of proof that the situation was unavoidable, the excessive costs will be disallowed.

The State reserves the right to make determinations of allowable costs in areas not specifically covered in the Principles or in the Rules and Regulations of Federal Medicare – Title XVIII.

Upper Limits

In no case may payment exceed the facility's customary charges to the general public for such services. The Upper Payment Limit is based on reasonable cost as is our payment.

Annual Cost Report

All facilities, with the exception of Public ICF-MR's, must file an annual cost report on a calendar year basis. The report format is determined by the Center for Adult Health's Rate Setting Unit and must be filed on or before March 31 following the close of the year.

The report must be completed in accordance with generally accepted accounting principles and prepared on the accrual basis of accounting wherein both revenues and expenditures are recognized in the period when earned or incurred regardless of when actual cash payments are made and received.

Providers who do not submit a cost report on time without written authorization extension from the Rate Setting Unit will be assigned a non-recoverable reduction of 20 percent of the previously assigned rate. Such rate reduction will continue on a month-to-month basis until said BM-64 is submitted or facility is terminated from the program for failure to file a cost report within six months from the close of the reporting year.

A final cost report must be filed within 90 days after a change in ownership, closing of the facility or when the provider leaves the Medicaid program.

Admission Policy

Participating Nursing Facilities must admit Title XIX patients to all parts of the facility without discrimination in accordance with the provisions of Section 23-17.5-19 and 23-27.5-21 of the Rhode Island General Laws based solely upon specialized medical and related needs of the patient. In addition, as provided in Section 23-17.5-24 of the Rhode Island General Laws, patients shall have the right to remain in a facility after the depletion of private funds.

METHOD OF PAYMENT TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED AND TO INTERMEDIATE CARE FACILITY PUBLIC INSTITUTION FOR THE RETARDED

The Principles of Reimbursement for Intermediate Care Facilities for the Mentally Retarded will be HIM-15, Federal Medicare, with the exclusion of the provision for a return on net equity.

Personal Clothing: ICF-MR

Rates of reimbursement assigned to Intermediate Care Facilities for the Mentally Retarded will include an amount not to exceed one dollar ($1.00) per day per client for the cost of purchasing personal clothing. This one dollar ($1.00) per diem allowance for clothing is not to be commingled with the facility's operating funds, personal needs funds, resident earnings or any other funds. A separate account is to be maintained by the facility which will account for all client personal clothing revenue and expenditures. The client personal clothing account will be summarized on individual client ledger cards showing name, dates of deposits, withdrawals and balance. Each withdrawal is to be substantiated by an itemized paid bill identifying the client name, articles of clothing purchased, and the date of purchase.

The client ledger cards for personal clothing, when totaled, will agree to the balance of the established separate personal clothing account. This reconciliation must be done on at least a monthly basis.

The recognized personal clothing expenditure for each client will not exceed the amount of one dollar ($1.00) per day. The facility will be responsible in monitoring the expenditures to ensure that this limitation is not exceeded.

Therefore, the clothing fund account for a resident must not have a negative balance. Clothing funds are considered to be on the accrual basis of accounting.

When a client dies, is discharged to a non-ICF-MR facility (waiver, apartment program, etc.), is discharged to a ICF-MR which is not part of the same corporation, or is discharged to the community, it will be necessary for the facility to transmit to the Department of Human Services, Rate Setting Unit, any unexpended funds from that resident's Personal Clothing Account within a period of twenty days.

If a facility is decertified from the ICF-MR Program, or voluntarily withdraws from the Program, the entire amount from each residents personal clothing account must be remitted to the Department of Human Services, Rate Setting Unit within twenty days.

As of January 31 of each calendar year, it will be necessary for the facility to remit to the Department of Human Services any unexpected or unencumbered funds in individual clothing accounts in excess of $90.00 recorded as of midnight on December 31 of the previous year.

Audits will be conducted on these accounts periodically in order to ensure compliance with the above-specified requirement.

Method of Determining Individual Rates

Each facility will be assigned an interim rate either based on an approval budget request or the previous years cost report pending submission of the annual cost report to determine the retroactive settlement rate. Rates based on a proposed budget or cost reports are determined by the Department's Rate Setting Unit. Reimbursement is based on a retrospective system.

Appeals Process

Any provider who is not in agreement, after being provided an exit audit conference or rate appeal conference, with the final rate of reimbursement assigned as the result of the audit for their base year, or with the application of the Principles of Reimbursement for the applicable calendar years, may within 15 days from the date of notification of audit results or rate assignments file a written request for a review conference to be conducted by the Associate Director, Division of Health Care, Quality, Financing and Purchasing or other designee assigned

by the Director of the Department of Human Services. The written request must identify the remaining contested audit adjustment(s) or rate assignment issue(s). The Associate Director or designee shall schedule a review conference within 15 days of receipt of said request. As a result of the review conference, the Associate Director or designee may modify the audit adjustments and the rate of reimbursement. The Associate Director or designee shall provide the provider with a written decision within 30 days from the date of the review conference.

Appeals beyond the Associate Director or the designee appointed by the Director of the Department of Human Services will be in accordance with the Administrative Procedures Act. The provider must file a written request for an Administrative Procedures Act hearing no later than 15 days of the decision noted in the paragraph above.

Transactions Which Reduce Reported Cost of Patient Care

Operations may result in the receipt of revenue from sources other than the direct care of patients. Where it is determined that these amounts are in fact reductions of previously incurred costs or are added revenue associated with the business purposes of the facility, such amounts must be offset against operating costs. For example, sale of meals, interest income, sale of supplies, etc., should be used to reduce costs.

Refunds, Discounts, and Allowances

Refunds, discounts and allowances received on purchased goods or services must be netted against the purchase price.

Medicine Chest Supplies, Transportation and Laundry Expenses

The per diem and interim per diem rates that are established include the reported expenses of nursing and medicine chest supplies, transportation of patients who can be transported by auto to and from physician's office, dental services, medical laboratories and hospitals for outpatient treatment; as well as laundry expenses including personal laundry with

the exception of dry cleaning costs; therefore, facilities must not charge Title XIX patient or their relatives for these services.

Payments

The State of Rhode Island reimburses a provider monthly for Medicaid patient days times the assigned prospective per diem rate.

The State of Rhode Island reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

In determining the number of days for which payment may be made, the date of admission is counted; however, the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under the State General Law Section 40-8.2-3 and Federal regulations, subsidy for patient care by either the patient, relatives or friends to the facility in any manner is prohibited.

Recordkeeping

Adequacy of Cost Information

Providers of ICF-MR services under the State Medicaid Program are required to maintain detailed records supporting the expenses incurred for services provided to Medicaid patients. The underlying records must be auditable and capable to substantiating the reasonableness of specific reported costs. Records include all ledger, books and source documents (invoices, purchase orders, time cards or other employee attendance data, etc.) All records must be physically maintained within the State of Rhode Island.

Audit of Provider Costs

In accordance with 45 CFR-250.30p.(3) (ii) (B) all cost reports will be desk audited within six months of submission.

The State of Rhode Island, Rate Setting Unit, shall conduct audits of the financial and statistical records of each participating provider in operation.

Audits will be conducted under generally accepted auditing standards and will insure that providers are reporting under generally accepted accounting principles.

Other matters of audit significance which will be undertaken are the examination of construction costs and final cost reports. All costs of new construction will be audited by the State as herein described. Final cost reports submitted by a provider due to change in ownership, closing of a facility or discontinuance in the Medicaid Program shall be subject to audit within a reasonable time after such change has taken place.

Services and affiliated organizations where common ownerships exits shall also be subject to audit. The extent of the audits will depend primarily on the relative dollar impact of these service groups (see page for definition of service and affiliated organizations).

Audits will include any tests of the provider's records deemed necessary to ascertain that costs are proper and in accordance with Medicaid Principles of Reimbursement and that personal needs accountability is in compliance with existing regulations. The knowing and willful inclusion on non-business related expenses, non-patient related expenses, or costs incurred in violation of the prudent buyer concept may be subject to criminal and/or civil sanctions. Failure of auditors of the Department to identify the above items or their adjustment of same shall not constitute a waiver of any civil or criminal penalty.